Credentialing and Privileging: Introductory Guidance

Background

Credentialing and privileging are the processes by which health centers ensure that their health care practitioners are competent and properly qualified to provide care to patients. These processes are vitally important to protect patient safety, provide high-quality health care services, reduce medical errors, and avoid potential legal liabilities. It is very important that health centers understand their responsibilities with respect to credentialing and privileging and implement appropriate programs to meet these responsibilities. Otherwise, health centers run the risk of disapproval of the deeming application or creating malpractice liability. For more information regarding Federal Tort Claims Act ("FTCA") coverage, see Providing care and Federal Tort Claims Act Coverage: Introductory Guidance.

Establishing comprehensive credentialing and privileging policies and procedures and consistent implementation are not optional activities. Federal law and Health Resources and Services Administration ("HRSA") policy require that health centers establish a formal process for the regular verification of the credentials of health care practitioners and the definition of their privileges. Specifically, the Federally Supported Health Centers Assistance Act of 1992[1] requires all health centers that participate in the FTCA program to credential all physicians and other licensed or certified health care practitioners.

HRSA policy on credentialing and privileging can be found in the two Policy Information Notices:

- PIN 2001-16 *Credentialing and Privileging of Health Center Practitioners* (July 17, 2001)
- PIN 2002-22 *Clarification of Bureau of Primary Health Care Credentialing and Privileging Policy Outlined in Policy Information Notice 2001-16* (July 10, 2002)

A health center's credentialing and privileging process must assure that staff be "appropriately licensed or certified to perform the activities and procedures detailed within the health center's approved scope of project."[2]

Credentialing

Credentialing is the process of assessing and confirming the qualifications of a licensed or certified health care practitioner. Every health center must have in place a formal and documented program that ensures verification of all necessary credentials for every job applicant. Primary Source Verification is a process of verifying a specific credential by

[1] Pub. L. No. 102-501 (Sept. 24, 1992).
[2] See Health Resources and Services Administration, *Health Center Site Visit Guide* (November 2014) p. 6.

obtaining appropriate information from the original source providing the credential. Methods of primary source verification may include direct correspondence, telephone verification, internet verification, and reports from credential verification organizations. A specific example of primary source verification is the health center's verification that a clinician's license is valid by calling the state licensing board, or, if made available by the licensing board, checking credentialing information on the agency's website.

In contrast, Secondary Source Verification is a process of verifying a specific credential through sources other than the original source, such as reviewing copies of relevant credentialing documents, e.g. a copy of a license. A specific example of secondary source verification would occur if a health center allows a clinician to provide copies of his or her immunization records or life support training rather than directly contacting the individual or organization that provided the immunizations or training.

HRSA specifies different verification requirements depending on whether the applicant is a Licensed Independent Practitioner ("LIP") or Other Licensed or Certified Health Care Practitioner ("OLCP")**.** LIPs include physicians, dentists, nurse practitioners, nurse midwives, and any other "individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges."[3] In other words, if the state licensing laws permit individuals to practice independent of physician supervision, and the health center chooses to allow such individuals to function independently, these clinicians are considered LIPs by HRSA and, therefore, must be credentialed as such.

OLCPs include individuals who are licensed, registered or certified but are not permitted by law to provide patient care services without direction and supervision. OLCPs include laboratory technicians, social workers, medical assistants, licensed practical nurses, and dental hygienists. These individuals must also be credentialed but not necessarily in accordance with the more strict standards applicable to LIPs, as outlined in the following chart.[4]

[3] PIN 2002-22 borrowed the definition of LIP from the Joint Commission, 2002-2003 Comprehensive Accreditation Manual for Ambulatory Care.

[4] Note that these are the definitions directly provided by PIN 2002-22. However, it is possible that a practitioner type mentioned in PIN 2002-22 as a LIP could be an OLCP if state law requires supervision for that category. A health center must check relevant state law and make a determination as to the appropriate category for particular practitioners.

Credentialing Requirements

Required verification of:	Method LIP	OLCP
☐ Licensure, registration, or certification	Primary source with local licensing, registration or certification board	Primary source with local licensing, registration or certification board
☐ Education	Primary source Medical/Graduate School or American Medical Association (AMA)/ American Osteopath Association (AOA) profile American Board of Medical Specialties (ABMS) Educational Commission for Foreign Medical Graduates (ECFMG) Federation of State Medical Boards (FSMB) American Academy of Physician Assistants Profile National Commission on Certification of Physician	Secondary source
☐ Training	Primary source	Secondary source
☐ Current competence	Primary source: Written observations from other professionals who have witnessed the practitioner work. Observations should address practitioner's actual experience as well as ethical performance.	Review of clinical qualifications and performance

Required verification of:	Method LIP	OLCP
☐ Health fitness (ability to perform the requested privileges)	Statement from individual that is confirmed either by the director of a training program, chief of staff/services at a hospital where privileges exist, or a licensed physician designated by the health center	Supervisory evaluation per job description
☐ National Practitioner Data Bank ☐ Query (malpractice history)	Required	Required
☐ Drug Enforcement Administration (DEA) registration, hospital admitting privileges	Secondary source, if applicable	Secondary source, if applicable
☐ Government issued picture Identification	Secondary source	Secondary source
☐ Immunization and PPD status	Secondary source	Secondary source
☐ Life support training (as applicable)	Secondary source, if applicable	Secondary source, if applicable

Privileging

Privileging is the process of authorizing the specific scope and content of a licensed or certified health care practitioner's patient care services. For many health centers, the scope of a practitioner's privileges is described in his or her job description or as part of his or her employment contract.

HRSA advises that health centers should re-privilege all of their licensed and certified practitioners at least every two years.[5] This re-privileging process necessarily entails re-checking of credentials, including primary source verification of credentials (e.g., verification of licensure, registration or certification). Health centers must also re-verify current competence

[5] PIN 2002-22.

through primary source based on peer review and/or performance improvement data. It is also advisable to re-verify the health status of all practitioners. This can be done through a written statement from the practitioner, countersigned by a licensed physician designated by the health center.

It is important to note that HRSA policy states that health centers should have an appeals process for LIPs if a decision is made to discontinue or deny privileges, but that an appeals process is optional for OLCPs.

Advice and Recommendations[6]

Credentialing and privileging play a vital role in protecting patients, ensuring quality of care, and avoiding unnecessary and potentially costly litigation. Health centers should consider credentialing and privileging as ongoing processes that promote the ability to fulfill their mission. As such, it is important that health centers understand their obligations with respect to credentialing and privileging, and, consistent with federal and state law and HRSA policy, implement appropriate policies and procedures to carry-out these duties.

Drafting and Implementing Clear, Written Policies

It is essential that health centers have a formal credentialing and privileging policy and procedure that is reviewed and approved by the Board of Directors. A health center should ensure that the minutes of the Board of Directors' meeting reflect that it approved the health center's credentialing and privileging policies and procedures. Board minutes (or committee minutes or management's documentation) should also reflect the approval of the credentialing and privileging of specific practitioners by the Board. Any delegation of approval authority made by the Board of Directors should also be clearly documented by a Board resolution.

A health center's credentialing and privileging policy and procedure should, at a minimum, comply with HRSA guidelines as set forth in the relevant PINs 2001-16 and 2002-22. The Authors recommend that all health centers go beyond those guidelines and require additional and more stringent verifications (e.g., criminal background checks and queries to relevant exclusion/debarment lists). A credentialing and privileging policy and procedure should be in writing and should require the health center to document all primary and secondary source verification. Practitioners' privileges should be recorded in writing. Supporting documentation for credentialing and the description of privileges should be maintained in each practitioner's personnel file which is kept in a locked, secure location with restricted access.

- Credentialing and privileging: Sample policy and procedure

[6] The Authors of these materials include attorneys at the law firm of Feldesman Tucker Leifer Fidell LLP. The advice and recommendations consist of general guidance based on federal law and regulations and do not necessarily apply to all health centers under all facts and circumstances. Further, these materials do not replace, and are not a substitute for, legal advice from qualified legal counsel.

Health centers should carefully review any contracts they have with managed care organizations and/or insurance companies as these contracts may require that health centers put in place credentialing programs that comply with more stringent requirements, such as those set forth by the National Committee for Quality Assurance ("NCQA").

Credentialing

A sound credentialing policy will allow health centers to identify high-risk providers with a history of malpractice problems or licensure actions. An important part of the credentialing process should be a review of lists regarding exclusion from participating in a federal health care program (OIG, SAM, state lists, etc.). Failure to appropriately verify a provider's credentials subjects a health center to many liability issues. Moreover, failure to establish and then follow a sound credentialing policy may also lead to a denial of deeming under the Federally Supported Health Centers Assistance Act. Employing or contracting with a debarred or suspended individual, can result in substantial financial penalties.

Credentialing should be completed before any individual is allowed to provide patient care services. Note that the requirements summarized above are considered a minimum, and the health center may elect to obtain additional verifications. For example, it is advisable also to query the National Practitioner Data Bank[7] for any potential sanctions and exclusions. Health Centers should consider using the Continuous Query system provided by the National Practitioner Data Bank.

The final determination that a licensed or certified health care practitioner meets all of the credentialing requirements should be documented in writing. Supporting documentation for credentialing and the description of privileges should be maintained in each practitioner's personnel file which is kept in a locked, secure location with restricted access.

Privileging

It is important that the health center grant privileges only for services that the health center has the infrastructure and capability to support. Health centers should review their scope of project and insure that the privileges it grants to its providers are related to the grant supported activities.

If the practitioner is privileged to provide services outside of a health center's scope of project, the health center should insure that professional liability insurance is available for the practitioner with respect to such services. Failure to secure additional professional liability coverage could result in potentially devastating financial liability for a health center if the

[7] More information about the National Practitioner Data Bank, including the e-Guidebook is available at: http://www.npdb.hrsa.gov/

practitioner and/or the health center are named in a malpractice suit for services that are outside of the center's scope of project and not otherwise covered by liability insurance.

Drafting and Implementing Confidentiality Policies

Clear confidentiality policies should apply to the credentialing and privileging processes. Board members and other individuals or committees involved in these processes should share personal information about practitioners only with each other to determine whether or not to hire, terminate and/or privilege the particular person at issue. No one may disclose a practitioner's credentials to parties outside of the credentialing and privileging processes unless, of course, there is a separate duty to report information (e.g., discovery of a previously unreported criminal violation, duty to report to the National Practitioner Data Bank, etc.). Moreover, information contained in personnel files relating to credentials and privileging should be kept in a locked, sure location with restricted access.

Contracting Out the Credentialing and Privileging Process

It is permissible for a health center to contract with a credentials verification organization ("CVO") that will gather and organize much of the information required for credentialing. CVOs can be extraordinary time savers for health centers, making any added financial costs to the health center cost effective.

It is important to note, however, that use of such agencies does not relieve a health center of the duty of securing complete and accurate information. If a CVO is negligent in verifying or providing credentialing information, the health center would continue to be responsible for the consequences of that negligence, unless the health center included an appropriate indemnification provision in its agreement with the CVO. The Joint Commission advises that, before contracting with a CVO, an entity should evaluate various factors to determine whether the CVO can properly verify and provide credentialing information. These factors are outlined in Appendix A of PIN 2002-22.

Legal Consequences of Non-Compliance

Failure to credential and privilege as required is not only dangerous from the standpoint of patient safety—it can result in costly and burdensome litigation for health centers. Essentially, there are two potential types of liability: third-party liability resulting from negligent or inappropriate credentialing and suits brought by a patient on account of a health center's actions with respect to credentialing or the granting of privileges to the practitioner.

Potential third party liability

Denial of FTCA Coverage: As discussed above, the Federally Supported Health Centers Assistance Act of 1992 requires that health centers properly credential their practitioners as a

condition of FTCA program participation. Consequently, failure to do so could result in failure to be "deemed" for purposes of FTCA coverage. The consequences of a denial of FTCA deeming cannot be understated. In addition to the high cost of insurance premiums, a single malpractice suit (in the absence of FTCA or expensive commercial liability insurance coverage) could force a health center into bankruptcy.

Negligence: In many states, a claim of "negligent credentialing" can be asserted against health care entities that fail to credential or improperly credential a practitioner. Typically, patients bring these types of actions because they have been harmed by a practitioner who they claim was not qualified to perform the services. These types of suits are premised on the fact that the health care entity should have discovered that the practitioner was not qualified during the credentialing and privileging process.

For health centers that purchase clinical capacity from another health care entity (e.g., a hospital) as part of an arrangement whereby clinicians employed by that entity are providing services to health center patients on behalf of the health center, it is advisable to secure an agreement specifying that all contracted practitioners must be screened through the health center's credentialing and privileging processes and approved before providing care to patients. Health centers should not proceed with an arrangement without such an agreement in writing.

Liability to Practitioners

Defamation: Most states recognize the "tort" of defamation. A defamation lawsuit can result if an individual or organization causes harm to another's reputation by publishing (even to only one other person) untrue information about that person. A health center may inadvertently defame a practitioner in several ways during the credentialing and privileging processes. For example, a practitioner could sue a health center for defamation if a member of the Board of Directors untruthfully told a third party that such practitioner was not hired or privileged because he or she was not competent to treat patients. Similarly, a health center employee who informs another health care entity that a practitioner was not hired or retained because he or she was a "bad" doctor may precipitate a defamation claim.

Privacy violations: It is unlawful in every state for a health center to disclose (intentionally or unintentionally), without consent, personal credentialing and privileging information, even if true, about a practitioner to any person or entity not involved in the credentialing and privileging processes or otherwise having no need to know such information. For example, failure to provide physical safeguards to protect practitioners' personnel files or the disclosure of credentialing information to third parties without consent could lead to a privacy lawsuit. As a result, health centers should limit access to credentialing and privileging information to only those who need it to fulfill their responsibilities to the health center and be very careful to train anyone with access that such information is strictly confidential and that it must not be discussed with anyone who does not have a clear legal entitlement to the information.

Wrongful Denial of Privileges

As stated above, HRSA requires that health centers have an appeals process in place for LIPs whose privileges are denied or revoked. In simplest terms, this means that if a health center refuses to privilege/re-privilege or terminates a practitioner based upon credentialing information, including performance-related information, the health center must give the practitioner an opportunity to appeal the decision. Failure to allow the practitioner to appeal the decision could create unnecessary legal problems for the health center, including a potential wrongful termination case.

While the structure and complexity of the appeals process will vary widely depending upon the size of a health center, at a minimum it should include the review of the practitioner's credentialing and/or privileging file by an individual or committee that was not directly involved in the initial credentialing / privileging process. For health centers purchasing clinical capacity from another entity, it is advisable to secure a release from the contracting entity specifying that it will not dispute a health center's decision to reject the appointment of a practitioner who does not meet the health center's credentialing and privileging standards.

Educating Practitioners about the Credentialing and Privileging Processes

Health centers should educate practitioners about the importance and necessity of the credentialing and privileging processes and the detrimental consequence of non-compliance. If practitioners better understand the role of credentialing and privileging, they will come to understand that these processes are not unnecessary or overly intrusive, but reasonable and designed to protect patient safety and assure quality of care.

Health centers can accomplish this type of education in a number of ways. One simple approach is to provide written materials, explaining the rationale behind these processes, the ramifications of non-compliance, and a checklist of duties for both the practitioner and the health center. It is the health center's responsibility to ensure that it complies with credentialing and privileging requirements and, in situations where practitioners refuse to comply or fail to meet deadlines for submission of information, the health center must have in place a method for disciplining practitioners or some other type of recourse in order to ensure that it does not incur liability because it was unable to timely credential and privilege practitioners.